NOVEMBER 1999
WEST VIRGINIA INFORMATIONAL LETTER

NO. 117

TO: ALL HEALTH MAINTENANCE ORGANIZATIONS LICENSED SEEKING RENEWAL OF CERTIFICATES OF AUTHORITY

RE: HEALTH MAINTENANCE ORGANIZATION RENEWAL APPLICATION CHECKLIST

West Virginia Code Section 33-25A-3A(3) provides that effective June 7, 1996, all certificates of authority issued to health maintenance organizations expire at midnight on May 31 of each year. To assist in the 2000 renewal process this Office has developed the enclosed "Health Maintenance Organization Renewal Application Checklist."

This form, along with all requested information and documentation, must be completed and submitted to the Commissioner for renewal of a certificate of authority on or before the first day of February. This renewal application filing date allows a full one hundred twenty day review period
granted the Commissioner by W. Va. Code Section 33-25A-4(2). Renewal applications will not be
considered completed until all required information and documentation are received.

In the application process for a renewal of a certificate of authority, health maintenance organizations may describe relevant or reference documents previously filed with this Department. Incomplete items or items not previously filed should accompany the renewal application. Additionally, if any of the original organizational documents have been modified, copies of the Commissioner's approval of all such changes should be filed. Please note that the certificate of authority renewal process is not a substitute for, or in lieu of, holding company filings or major modification filings.

Completed applications and accompanying documentation are to be mailed to:

Mailing Address:	Street Address:
West Virginia Insurance Commission	West Virginia Insurance Commission
Financial Conditions Division	Financial Conditions Division
P.O. Box 50540	1124 Smith Street, Room 404
Charleston, West Virginia 25305-0540	Charleston, West Virginia 25301

Please direct any questions regarding the Grievance Procedure to Kathleen A. Beck, Director, Consumer Services Division. Questions concerning Quality Assurance should be directed to Cathy J. Ayersman, Director Consumer Advocacy Division. All other questions regarding the "Health Maintenance Organization Application Guidelines and Checklist for Certificate of Authority" should be directed to either Robert E. Cadle or Jamie O. Taylor with the Financial Conditions Division.

Hanley C. Clark
Insurance Commissioner

STATE OF WEST VIRGINIA
INSURANCE COMMISSIONER

HEALTH MAINTENANCE ORGANIZATION APPLICATION GUIDELINES AND CHECKLIST FOR CERTIFICATE OF AUTHORITY

CHAPTER 33, ARTICLE 25A OF THE WEST VIRGINIA CODE

☐ Initial Application

☐ Renewal for Year Beginning June 1, 19___

Mail Completed Application to:

West Virginia Insurance Commission
Financial Conditions Division
P.O. Box 50540
Charleston, West Virginia 25305-0540

Pursuant to Chapter 33, Article 25A, of the West Virginia Code, the application is hereby submitted to form and operate a Health Maintenance Organization ("HMO").

Name, trade name and address of the Health Maintenance Organization Applicant:

NAME: _____
TRADE NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP CODE: _____
PHONE: (_____)_____

ATTORNEY OR PRINCIPAL FILING THIS APPLICATION ON BEHALF OF THE HMO APPLICANT:

NAME: _____

ADDRESS: _____

STATE: _____ ZIP CODE: _____

PHONE: (_____)_____

HMO RENEWAL APPLICATION CHECKLIST

INTRODUCTION

For continued operation in West Virginia, each HMO must apply for and receive a Certificate of Authority from the Insurance Commissioner. Each renewal application must set forth and be accompanied by the required information and documentation. The Commissioner shall renew or deny a Certificate of Authority to any HMO filing a renewal application within one hundred twenty days after receipt of the **completed** application. **IMPORTANT: A renewal application will not be considered complete until all required information and documentation has been submitted to the Commissioner, and the applicant has fully complied with all provisions or requirements of these guidelines and/or applicable law**. The fully completed renewal application must be filed with the Commissioner on or before the first day of February.

INSTRUCTIONS

1. A completed renewal application checklist and appropriate verification must be submitted.

2. All information must be placed in three-inch binder(s) and be separated by numbered tabs which correspond to the numbered requests in the application checklist. For example: Application Question No. 5 asks for certification from a Director or Officer stating that basic health care services are available and accessible. The certification should be placed under Tab No. 5(a) in the binder.

3. Documents must have page numbers which should begin with the corresponding Tab No. and a dash (-). For Example: If the certification is two pages long, each page should be numbered 5(a)-1 and 5(a)-2.

4. If replacement pages are necessary, they should specifically note what pages are being replaced. For example: If the certification was incorrect and had to be replaced, the pages should be numbered Replacement 5(a)-1 and Replacement 5(a)-2, etc. If the documents merely supplement existing documents, the pages should be marked Supplemental and should use a letter of the alphabet. For example: If page 5(a)-1 of the certification is being supplemented it should be numbered Supplemental 5(a)-1(a).

5. Each renewal application box should be checkmarked (√) when the information requested has been provided. **REMEMBER**: Each renewal application must be verified to make sure that the documents and information have been provided before completing and sending the checklist and verification.

6. Page numbers indicating the information and/or document location(s) must be clearly marked on the space provided.

NOTE: The information requested by the Renewal Application checklist constitutes the minimum necessary to begin the 120-day Certificate of Authority review cycle. The Commissioner reserves the right to ask for and obtain additional information and/or documents from an applicant at any time prior to the deemer date in order to determine whether to grant a Certificate of Authority.

HMO RENEWAL APPLICATION CHECKLIST

I. CERTIFICATE OF AUTHORITY

Page(s)
Location

☐ __ 1. Each renewal application for a Certificate of Authority must be verified by an officer or authorized representative of the applicant.

- ☐ __ a. A verification form entitled "CERTIFICATION" is included with this renewal application packet and must be completed and filed with each renewal application.
- ☐ __ b. Attach a copy of the corporate resolution appointing the individual as the authorized representative of the HMO.

☐ __ 2. Complete the enclosed "HEALTH MAINTENANCE ORGANIZATION APPLICATION FOR A CERTIFICATE OF AUTHORITY FILING FEE REMITTANCE FORM."

- ☐ ___ Attach a check in the amount of $200 made payable to the "Insurance Commissioner of West Virginia."

☐ ___ 3. File an **original and two copies** of the application with the West Virginia Insurance Commissioner. The Commissioner may request additional copies.

☐ ___ 4. File a copy of page 1 of this renewal application with:

Marianne K. Stonestreet, General Counsel
Health Care Cost Review Authority
100 Dee Drive, Suite 201
Charleston, WV 25311-1692

II. ORGANIZATIONAL/MANAGERIAL

☐ ___ 5. As required by W. Va. Code §33-25A-4(2)(a) the HMO must:

- ☐ ___ a. Submit a certification from an authorized representative that the HMO has current documents on file with the Commissioner that assure basic health services will be provided in a manner to enhance and assure both the availability and accessibility of adequate personnel and facilities.
- ☐ ___ b. Submit a copy of the most recent provider directory along with a summary of contracted providers in the service area. The summary should be prepared for each licensed county and be in the following format:

County	No. Contracted
PCP	#
PED	#
OB/GYN	#
SPEC	#

☐ ___ c. Submit the organizations procedures to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, and the quality, availability and accessibility of its services.

☐ ___ 6. Submit copies of the cover letter(s) bearing the West Virginia approval stamp of all rates and forms currently in use by the HMO. Also, submit copies of each Summary of Benefits for each type of member, i.e. PEIA, Commercial, etc.

☐ ___ 7. Submit the following pursuant to W. Va. Code § 33-25A-4(2)(c):

☐ ___ a. Documentary evidence that the HMO is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees.

☐ ___ b. Evidence of the financial soundness of the HMO's arrangements for the health services and proposed schedule of charges used in connection with health care services.

☐ ___ c. State the amount of HMO's capital and/or surplus:

☐ ___ 1. For profit stock corporation:

☐ ___ Fully paid-in capital stock (at least 1,000,000) $_____

☐ ___ Additional surplus (at least $1,000,000) $_____

☐ ___ 2. For profit stock corporation:

☐ ___ Statutory surplus (at least 1,000,000) $_____

☐ ___ Additional surplus (at least $1,000,000) $_____

☐ ___ d. Submit a copy of the relevant page(s) of any arrangement (reinsurance agreement) containing the provisions:

☐ ___1. Stop loss provisions, which covers catastrophic losses incurred up to insolvency.

☐ ___2. Out of area conversions, which provides conversion coverage to enrollees who move out of area "bridge coverage."

☐ ___3. Continuation of benefits and payments to providers for services rendered both prior to and after insolvency for the duration of the contract period for which payment has been made, except that benefits to members who are confined on the date of insolvency in an inpatient facility shall be continued until their discharge.

☐ ___ e. Any agreement that provides for the provision of health care services that is not currently on file with the Commissioner.

☐ ___ 8. Submit a description of any reasonable provisions that have been made for emergency and out-of-area health care services.

☐ ___ 9. The HMO must submit documentation that it will assume full financial risk on a prospective basis for the provision of health care services, including hospital care: Provided, that the requirement of this subdivision, shall not prohibit a HMO from obtaining reinsurance acceptable to the Commissioner from an accredited reinsurer or making other arrangements acceptable to the Commissioner:

☐ ___ For the cost of providing to any enrollee health care services, the aggregate value

of which exceeds for thousand dollars in any year.

☐ ___ For the cost of providing health care services to its members on a nonelective emergency basis, or while they are outside the are served by the organization.

☐ ___ For not more than ninety-five percent of the amount by which the HMO's costs for any of its fiscal years exceed one hundred five percent of its income for those fiscal years.

Note: A Director of Officer must submit certification stating that all reinsurance contracts have previously been submitted to this Department.

☐ ___10. Submit a brief description of each Intermediary Contract currently in force with the HMO, pursuant to §114 WV CSR 43.

☐ ___11. Pursuant to W. Va. Code § 33-39-1, *et seq.*, every insurer domiciled in this state shall disclose material acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance programs, unless approved by the commissioner through Insurance Holding Company Systems Filings. List all material transactions which occurred during the past calendar year.

☐ ___12. Submit certification stating that the ownership, control and management of the organization does not include any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors or creditors.

☐ __13. Include a completed BIOGRAPHICAL STATEMENT AND AFFIDAVIT for any appointed officer, director, manager, administrator or person holding 5% or more of the common stock of the organization that is not currently on file with the Commissioner.

☐ __14. Submit a certification stating that BIOGRAPHICAL STATEMENT AND AFFIDAVIT forms previously filed with this office have not changed and/or submit a revised AFFIDAVIT for all officers, etc., that have changed.

☐ ___15. Does the HMO maintain a deposit in trust with the state treasurer, for the protection of its subscribers or its subscribers and creditors, cash or government securities eligible for the investment of capital funds of domestic insurers as described in W. Va. § 33-8-7, in the amount of one hundred thousand dollars?

III. GRIEVANCES & APPEALS

☐ ___16. Submit a detailed description of applicant's subscriber grievance and appeal procedures and include a statement that the HMO shall have someone with decision-making authority at each level of the process.

☐ ___17. Provide samples of group and individual contracts and certificate or member handbooks given to subscribers. Each shall include:

☐ __ a. Formal and informal steps to resolve grievances;

☐ ___ b. Toll-free telephone numbers for the subscriber to call to present an informal grievance or to contact the grievance coordinator;

☐ ___ c. An address for written grievances;

☐ ___ d. A detailed description of the appeal process;

☐ ___ e. A description of the statute of limitations for filing grievances;

☐ ___ f. A statement outlining the time frame in which grievances shall be processed;

☐ ___ g. A statement that there is physician involvement in the review of medically-related grievances; and

☐ ___ h. A statement that time sensitive grievances will be handled on an expedited basis.

☐ ___18. Submit a copy of the policies and procedures for administering formal and informal grievances.

☐ ___19. Provide the name, address and telephone number of the grievance coordinator(s) who is/are responsible for the implementation of the grievance procedure.

IV. QUALITY ASSURANCE

20. For health maintenance organization that have been in existence at least three (3) years,

☐ __a. A copy of the **current** quality assurance report submitted to the HMO by a nationally recognized accreditation and review organization approved by the Commissioner; or

☐ __b. Proof sufficient to demonstrate that the HMO has timely applied for and reasonably pursued a review of its quality assurance program; or

☐ __c. Indicate date the last quality assurance report was filed with and approved by the Commissioner: _____.
(mo/day/yr)

Important Note:

- If the HMO has not been in existence at least three (3) years, documentation as required by the standards set forth in this section must be submitted to verify compliance.
- If the HMO has been in existence three (3) years or more, a copy of an Accreditation Report performed by a nationally recognized accreditation and review organization may be submitted to verify compliance. That report must, however, contain evidence that the quality assurance standards listed below in this section have been met. When necessary, separate documentation, as required by those standards, may be submitted to supplement the quality assurance report.
- If the HMO has undergone a pre-accreditation review (PAR), the PAR report may be submitted and supplemented, if necessary, by separate documentation as required by the standards set forth in this section. The PAR report and any additional documentation must verify compliance with the quality assurance standards.

Please check those standards listed below which have been met by the quality assurance program and indicate where in the quality assurance report or in separate documentation those standards can be found. **Subsequent to approval of the quality assurance program, any modification of the program must be filed with and approved by the Commissioner.**

21. To establish quality management and improvement provide:

☐ __a. Written description of the Quality Improvement (QI) program that outlines program structure and design.

☐ __b. Statement that description is reviewed annually and updated as necessary.

☐ __c. Name, address and telephone number of senior executive responsible for program implementation.

☐ __d. Name, address and telephone umber of the Medical Director.

☐ __e. Is Medical Director full time or part time?

☐ __f. Evidence that Medical Director has substantial involvement in QI activities.

☐ __g. Evidence of a committee that oversees and is involved in QI activities.

☐ __h. Description of the role, structure and function, including frequency of meetings, of the QI Committee.

☐ __i. Evidence that providers participate actively in the QI committee.

☐ __j. Evidence of contemporaneous records reflecting actions of the committee.

☐ __k. A copy of the annual QI work plan, or schedule of activities, that includes the following:

☐ __1. Objectives, scope, and planned projects or activities for the year;

☐ __2. Planned monitoring of previously identified issues, including tracking thereof over time; and

☐ __3. Planned evaluation of the QI program.

22. To establish accountability to the governing body provide:

☐ __a. Documentation that the governing body has approved the QI Committee's overall QI program and the annual QI work plan.

☐ __b. Evidence that the governing body or designated committee receives regular written reports from the QI program delineating actions taken and improvements made.

☐ __c. Evidence that the governing body reviews a written annual report on the QI program.

☐ __d. Evidence that QI information is used in recredentialing, recontracting, and/or annual performance evaluations.

23. To establish coordination with other management activity provide:

☐ __a. Evidence that QI activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution and monitoring of member complaints and grievances.

☐ __b. Evidence of linkage between QI and other management functions of the managed care organization, e.g., network changes, benefits redesign, medical management systems, practice feedback to providers and patient education.

24. Provider contracts should contain or include:

☐ __a. Requirements to participate in QI activities are incorporated into all provider contracts and employment agreements.

☐ __b. A specification that hospitals and other contractors will allow the managed care organization access to the medical records of their members.

☐ __c. A provision that the health maintenance organization allows open provider-patient communication regarding appropriate treatment alternatives and that it does not penalize the provider for discussing medically necessary or appropriate care for the patient.

25. To establish that the quality assurance program is designed to objectively and systematically monitor and evaluate the quality and appropriateness of care provide:

☐ __a. Evidence of member participation in QI.

☐ __b. Evidence that the monitoring and evaluation of clinical issues reflect the population served by the managed care organization in terms of age groups, disease categories, and special risk status. Identify the following:

☐ __1. Services provided in institutional settings;

☐ __2. Services provided in noninstitutional settings, including but not limited to, practitioner offices and home care.

☐ __3. Primary care and major specialty services, including mental health.

☐ __4. High-volume, high-risk services, and the care of acute and chronic conditions.

26. To establish important aspects of care and service provide:

☐ __a. The process for periodically updating the practice guidelines.

☐ __b. The mechanism for communicating the practice guidelines to managed care organization providers has been implemented.

☐ __c. How performance is assessed against the practice guidelines.

☐ __d. A description of the evaluation process for member continuity and coordination of care.

☐ __e A description of mechanisms to detect under and over utilization.

☐ __f. A description of mechanisms used to assess patient outcomes.

27. To establish access to care and service provide:

☐ __a. A copy of the standards for the availability of or access to primary care providers, e.g., routine, urgent and emergency care.

☐ __b. A description of the process for identifying members with chronic/high-risk illnesses and implementing appropriate programmatic responses.

☐ __c. A description of the procedures for handling/scheduling appointments by telephone and the use of advice and member service lines.

28. To establish quality measurement and improvement provide evidence that HMO has developed quality indicators that are objective, measurable and based on current knowledge and clinical experience and are used to monitor and evaluate each important aspect of care and service identified.

☐ __a. Identify performance goals and/or a bench-marking process for each indicator.

☐ __b. Identify the appropriate methods and frequency of data collection for each indicator.

☐ __c. Evidence that results of evaluations are used to improve clinical care and service.

☐ __d. The method of tracking areas for improvement to assure that appropriate action is taken and improvements are effective.

29. To establish utilization management provide:

☐ __a. Description of the UM program including policies and procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.

☐ __b Mechanism for updating the UM program description on a periodic basis.

☐ __c. Evidence that qualified medical professionals supervise review decisions where procedures are used for preauthorization and concurrent review.

☐ __d. Evidence that a duly licensed physician conducts a review for medical appropriateness on any denial.

☐ __e. Evidence that the managed care organization utilizes, as needed, licensed physician consultants from appropriate specialty areas of medicine.

☐ __f. Written utilization review decision protocols.

☐ __g. The mechanism for checking the consistency of application of criteria across reviewers.

☐ __h. The mechanism for periodically updating review criteria.

☐ __i. Description of information intake including pertinent clinical information and consultation with the treating physician.

☐ __j. Evidence that reasons for denial notification of appeal process are clearly documented and available to the member.

☐ __k. Written policies and procedures to evaluate the appropriate use of new medical technologies or new applications of established technologies, including medical procedures, drugs and devices.

☐ __l. Written policies and procedures for evaluating the effects of the program using member satisfaction data, provider satisfaction data, and/or other appropriate means.

☐ __m If any delegation of QI or UM activities to contractors, provide evidence of oversight of the contracted activity including:

- ☐ __1. the delegated activities;
- ☐ __2. the delegate's accountability for these activities;
- ☐ __3. the frequency of reporting to the HMO;
- ☐ __4. the process by which delegation will be evaluated;
- ☐ __5. approval of the delegate's UM program; and
- ☐ __6. evaluation of the regularly specified reports.

30. To establish that a system of credentialing is in place provide:

- ☐ __a. copy of the written policies and procedures for the credentialing process.
- ☐ __b. Evidence of a credentialing committee or other peer review body that makes recommendations regarding credentialing decisions.
- ☐ __c. Evidence that provider doctors serve as voting members of the credentialing committee.
- ☐ __d. The name, address, telephone number and area(s) of practice of each practitioner who falls under the HMO's scope of authority and action.
- ☐ __e. Evidence that the initial credentialing process is ongoing and up-to-date and that HMO obtains review verification of the following:
  - ☐ __1. A current valid license to practice;
  - ☐ __2. When applicable clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;
  - ☐ __3. A valid DEA certificate, as applicable;
  - ☐ __4. Graduation from medical school or appropriate graduate school and completion of a residency, specialty training or board certification, as applicable;
  - ☐ __5. Complete work history;
  - ☐ __6. Current adequate malpractice insurance according to the HMO's policy; and
  - ☐ __7. Complete professional liability claims history.
- ☐ __f. A copy of the form application for membership including a statement by the applicant regarding:
  - ☐ __1. reasons for any inability to perform the essential functions of the position with or without accommodation;
  - ☐ __2. lack of present illegal drug use and alcohol abuse;
  - ☐ __3 history of loss of license and for felony convictions;
  - ☐ __4. history of loss or limitation of privileges or disciplinary activity; and
  - ☐ __5. an attestation to the correctness/completeness of the application.

☐ __g. Evidence that the HMO requests information on the practitioner during credentialing and re-credentialing from the following recognized monitoring organizations:

- ☐ __1. National Practitioner Data Bank;
- ☐ __2. The appropriate State licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board and/or Dental Board; and
- ☐ __3. Medicare/Medicaid sanctioning.

☐ __h. Evidence of an initial visit to each potential primary care practitioner's office and to the offices of obstetricians/gynecologists and other high-volume specialists resulting in documentation of a structured review of the site and of medical record keeping practices to ensure conformance with HMO's standards.

☐ __i. Evidence of the periodic verification of credentials that is ongoing and up-to-date and implemented at least every two years.

☐ __j. Evidence that recredentialing, recertification, or reappointment process includes verification from primary sources of:

- ☐ __1. current valid license to practice;
- ☐ __2. when applicable, clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;
- ☐ __3. a valid DEA certificate, as applicable;
- ☐ __4. board certification, as applicable;
- ☐ __5. current, adequate malpractice insurance according to the HMO's policy; and
- ☐ __6. professional liability claims history.

☐ __k. Evidence that the recredentialing process includes a current statement by the applicant regarding:

- ☐ __1. inability to perform the essential functions of the position, with or without accommodation; and
- ☐ __2. lack of present illegal drug use or alcohol abuse.

☐ __l. Evidence that the recredentialing, recertification or performance appraisal process includes review data from:

- ☐ __1. member complaints and grievances;
- ☐ __2. results of quality reviews;
- ☐ __3. utilization management;
- ☐ __4. member satisfaction surveys
- ☐ __5. medical record reviews; and

☐ __m. Evidence that the recredentialing process includes an on-site visit to the offices of all primary care providers and OB/GYNs.

☐ __n. Copies of policies and procedures for reducing, suspending or terminating practitioner privileges which shall include:

- ☐ __1. a mechanism for reporting to the appropriate authorities serious quality

deficiencies resulting in suspension or termination; and

☐ __2. an appeal process for and notice thereof to the provider.

☐ __o. Copies of written policies and procedures for the initial quality assessment of all health delivery organizations including but not limited to hospitals, home health agencies, behavioral health agencies, nursing homes, skilled nursing facilities and free-standing surgical centers with which the HMO intends to contract.

☐ __1. When applicable, confirmation that health delivery organizations have been reviewed and approved by a recognized accrediting body and are in good standing with state and federal regulatory bodies; and

☐ __2. A copy of the standards of participation for health delivery organizations who have not been approved by a recognized accrediting body.

☐ __p. Evidence of oversight of any delegated credentialing/re-recredentialing activity to contractors including a written description of:

☐ __1. the delegated activities; and

☐ __2. the delegate's accountability for these activities.

☐ __q. Evidence that HMO monitors the effectiveness of the delegate's credentialing and reappointment or recertification processes at least annually.

31. To establish that members' rights and responsibilities are delineated in the quality process provide:

☐ __a. A copy of the HMO's written policy recognizing the right of members to:

☐ __1. voice grievances about the HMO or care provided;

☐ __2. have information concerning the HMO, its services, the practitioners providing care, and members' rights and responsibilities;

☐ __3. participate in decision-making regarding health care; and

☐ __4. be treated with respect and recognition of their dignity and need for privacy.

☐ __b. A copy of the HMO's written policy addressing members' responsibilities for cooperating with those health care providers by:

☐ __1. giving needed information to professional staff to ensure appropriate care; and

☐ __2. following instructions and guidelines given by health care providers.

☐ __c. A statement that the HMO provides a copy of policies on members' rights and responsibilities to all participating providers and directly to members.

☐ __d. Evidence that members are given written statements that are clear and concise and at a minimum address:

☐ __1. how to submit a claim for covered services;

☐ __2. how to obtain primary and specialty care, behavioral health services and hospital services;

☐ __3. after-hours and emergency coverage including the HMO's policy on when to

directly access emergency care or use 911 type services:

☐ __4. benefits and services included and excluded from membership;

☐ __5. obtaining out of area coverage;

☐ __6. special benefit provisions such as co-payment, higher deductibles and rejection of claims that may apply to services outside the system;

☐ __7. members charges

☐ __8. procedures for notifying those members affected by:

☐ __a. termination or change in any benefits,

☐ __b. termination of any services, or

☐ __c. termination of any service delivery office/site;

☐ __9. notification of termination of a primary care or specialty provider and the process for selecting a new provider;

☐ __10. procedures for appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization;

☐ __11. procedures for changing practitioners;

☐ __12. procedures for disenrollment of nongroup subscribers;

☐ __13. procedures for voicing complaints, grievances and appeals;

☐ __14. procedures for recommending changes in policies and services;

☐ __15. points of access to primary care, specialty care and hospital services;

☐ __16. the process by which a managed care organization determines whether or not to include new and emerging technology or treatment as a covered benefit;

☐ __17. information on provider names, qualifications and titles;

☐ __18. a copy of written policies and procedure pertaining to confidentiality; and

☐ __19. a copy of member satisfaction survey including an assessment of:

☐ __a. patient complaints;

☐ __b. requests to change practitioners and/or facilities; and

☐ __c. disenrollments by members.

☐ __20. Procedure by which a member can receive a standing referral to a specialist

☐ __e. Submit a detailed description and evidence as to how enrollees are afforded an opportunity to participate in matters of policy and operation pursuant to WV Code §33-25A-6.

☐ __f. Evidence of oversight of any delegated member service activities to contractors including a written description of:

☐ __1. delegated activities;

☐ __2. delegate's accountability for these activities;

☐ __3. frequency of reporting complaints and grievances and member survey data;

☐ __4. process by which the delegation will be evaluated;

☐ __5. approval of the delegate's member services program; and

☐ __6. evaluation of regularly specified reports.

32. To establish that the HMO engages in preventive health services provide:

☐ __a. Copies of practice guidelines and all updates for the use of preventive health services.

☐ __b. A statement that the guidelines are provided in writing to all providers and members

☐ __c. Evidence that the HMO monitors, evaluates and takes action to improve a minimum of two of the following:

☐ __ Childhood immunizations recognized by the American Academy of Pediatrics or as required by state or federal law.

☐ __ Adult immunizations:

☐ __ Influenza vaccine;

☐ __ Pneumococcal vaccine;

☐ __ Hepatitis B vaccine;

☐ __ Diphtheria and tetanus toxoid; and

☐ __ Rubella screening for women of childbearing age.

☐ __ Any other required by state or federal law.

☐ __ Coronary artery disease risk factor screening and/or counseling for smoking, cholesterol, exercise and hypertension

☐ __ Cancer screening;

☐ __ Breast; and

☐ __ Cervix.

☐ __ Counseling for prevention of motor vehicle injury;

☐ __ Lead toxicity screening;

☐ __ Sexually transmitted disease screening/prevention;

☐ __ Prenatal care;

☐ __ Human immunodeficiency virus (HIV)/ AIDS counseling, screening and education;

☐ __ Prevention of unintended pregnancy; and/or

☐ __ Alcohol and other drug abuse screening/prevention.

33. To establish that medical records are maintained in a manner that is current, detailed, organized, and permits effective patient care and quality review provide:

☐ __ a. A statement that records are available to health care practitioners at each patient visit and to nationally and state recognized reviewing bodies sanctioned by the Commissioner;

☐ __ b. A copy of standards and all updates for maintaining medical records, the systematic review for conformance and the institution of corrective action when standards are not met; and

☐ __ c. A statement that copies of all standards and goals and any updates are provided in writing to all providers.

CERTIFICATION

State of _____

County of _____

To-wit:

I, _____,do swear or affirm that I have carefully examined each of the questions asked in the **HEALTH MAINTENANCE ORGANIZATION APPLICATION AND CHECKLIST** and each of the responses thereto and, to the best of my knowledge and ability, all responses, information, exhibits, and documentary evidence submitted in support thereof are true and correct.

_____
(Type or Print name)

_____
(Title)

_____
(Signature)

_____
(Date)

Sworn to and subscribed before me this _____ day of_____ 19 _____

My commission expires: _____.

_____
(Notary Public)

(Notary Seal)